

Legal Disclaimer: The views and opinions contained in the educational offerings described in this publication do not necessarily reflect those of the Division of Mental Health and Substance Abuse or the Department of Health and Social Services, and should not be construed as such.

LEARNING CONTRACT

PLEASE PRINT

PLEASE COMPLETE ALL REQUESTED INFORMATION
TO ENSURE PROCESSING AND REGISTRATION

WORKSHOPS REQUESTED

LAST NAME	FIRST NAME	
BUSINESS / AGENCY ADDRESS		
CITY	STATE	ZIP CODE
()	()	
HOME PHONE	BUSINESS PHONE	
E-MAIL ADDRESS		

DISABLED (*CHECK ONE*) GENDER (*CHECK ONE*)
☐ YES ☐ NO ☐ M ☐ F

HIGHEST DEGREE COMPLETED (*CIRCLE ONE*)
HS GED AA LPN RN BA/S MA/S MSW PH/MD

I WILL BE APPLYING FOR CEU'S WITH:
(SEE THE CERTIFICATION SECTION OF THE DSAMH TRAINING CATALOG FOR DETAILS)

☐ CEAP ☐ DBN ☐ DCB ☐ DPA
☐ NAADAC ☐ NCC ☐ NCGC

AGENCY

Agency Code: **Agency Name:**
(see back of this form for list of agency codes)

POSITION: PLEASE CHECK THE ONE THAT BEST DESCRIBES YOU:

<input type="checkbox"/> Administrator/Manager	<input type="checkbox"/> Physician
<input type="checkbox"/> Aide/Outreach	<input type="checkbox"/> Prevention Worker
<input type="checkbox"/> Case Manager/Counselor/Therapist	<input type="checkbox"/> Psychologist
<input type="checkbox"/> Chaplain/Ministry	<input type="checkbox"/> Social Worker
<input type="checkbox"/> Consultant	<input type="checkbox"/> Student
<input type="checkbox"/> Consumer	<input type="checkbox"/> Supervisor (clinical)
<input type="checkbox"/> Educator/Teacher/Instructor	<input type="checkbox"/> Support Staff
<input type="checkbox"/> Employee Assistant Personnel	<input type="checkbox"/> Volunteer
<input type="checkbox"/> Nurse	<input type="checkbox"/> Other

ETHNICITY: (CIRCLE ONE)

Alaskan Native Asian American African American Caucasian
Hispanic Native American Pacific Islander Other _____

1)	WORKSHOP NUMBER	DATE
LOCATION		
WORKSHOP TITLE		How do you meet the prerequisite? (if applicable)
2)	WORKSHOP NUMBER	DATE
LOCATION		
WORKSHOP TITLE		How do you meet the prerequisite? (if applicable)
3)	WORKSHOP NUMBER	DATE
LOCATION		
WORKSHOP TITLE		How do you meet the prerequisite? (if applicable)

I understand that I should receive a confirmation of admission to a workshop before I attend. IF I AM NOT ABLE to attend a workshop, I will notify the Training Office at least 4 days in advance. I understand that all NO-SHOWS (someone who was admitted into a workshop, did not attend, and did not alert the Training Office) will be reported to my Program Director on a monthly basis.

APPLICANT SIGNATURE	DATE
SUPERVISOR SIGNATURE (REQUIRED)	DATE
SUPERVISOR FULL NAME (<i>PRINT ONLY</i>)	
SUPERVISOR E-MAIL	

ALL REQUESTED SIGNATURES ARE REQUIRED FOR
PROCESSING AND REGISTRATION

Mail or FAX the completed Learning Contract to:

DSAMH Training Office
Springer Building, 1901 N. Dupont Highway
New Castle, DE 19720
Fax: (302) 255-4450

HAVE QUESTIONS?

For further information, call (302) 255-9480
or e-mail us at DSAMH.training@state.de.us



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

AA. Aquila of Delaware, Inc.
AB. Brandywine Community Resource Council, Inc.
AC. Brandywine Counseling
AD. Carelink Community Support Services
AE. Central Delaware Committee on
 Drug & Alcohol Abuse
AF. Christiana Care Health Services
AG. Community Mental Health Centers
AH. Connections
AI. Delaware Council on Gambling Problems
AJ. Delaware Psychiatric Center
AK. Delmarva Rural Ministries
AL. Dover Behavioral Health
AM. DSAMH Central Office
AN. Fellowship Health Resources
AO. Gateway Foundation
AP. Gaudenzia, Inc.
AQ. Horizon Healthcare of Delaware
AR. Horizon House of Delaware
AS. Hudson Health Services
AT. K/S Detox Center
AU. Kent County Counseling
AV. La Red Health Center
AW. Latin American Community Center
AX. Limen House
AY. Mental Health Association
AZ. MLK Center
BA. National Alliance for the Mentally Ill of
 Delaware (NAMI-DE)
BB. NET (Delaware), Inc.
BC. OPEI (Office of Prevention and Early
 Intervention)
BD. Psychotherapeutic Services, Inc.
BE. Resources for Human Development
BF. Serenity Place
BG. SODAT
BH. Sussex County Counseling
BI. Treatment Access Centers
BJ. Thresholds, Inc.
BK. Universal Health Services
BL. Westside Health
BM. Whatcoat Social Services Agency, Inc.
BN. Other